
Transformation of the Health Care System in the Czech Republic – A Sociological Perspective

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The Czech Republic arose from the former Czechoslovakia, which was established after the disintegration of the Austrian–Hungarian Monarchy in 1918 as a democratic country with a modern industry and well-developed social and health care system. Czechoslovakia became a part of the Soviet Bloc after World War II. This merger impacted political, economic, and social life negatively. The only experience of political freedom came during the short period of the so-called “Prague Spring” which was curtailed by the Soviet occupation in 1968. Czechoslovakia finally became free after the “velvet” revolution in November 1989. In January 1993, the country was peacefully divided into two independent states – the Czech Republic and the Slovak Republic. The revolution meant the replacement of the totalitarian political model employed by the Soviet government with a modern pluralistic democracy open to political freedom, a market economy, and human rights.

MAIN DEMOGRAPHIC AND SOCIOECONOMIC CHARACTERISTICS

This small central European country, a member of NATO since 1999, occupies a territory of about 79,000 square kilometers and has about 10.3 million inhabitants with the density of population totaling 131 persons per square kilometer (Čáková 1999). The country is politically divided into 76 districts, each with about 120,000 inhabitants with the exception of the capital Prague, which contains 1.2 million people. Historically, there has been two parts: Bohemia on the west and Moravia on the east. The socioeconomic differences between regions are increasing in connection with the restructuralization of heavy industry and with rapidly growing unemployment in some regions. In northern and western Bohemia as well as in northern Moravia where coal

mines, heavy machinery, and chemical industry are traditionally concentrated, unemployment reaches 17.7 percent while in Prague it is only 2.7 percent. These regions are also characterized by a high level of social deprivation and pathology, ethnic problems, and bad environmental conditions. Also differences between big cities and the countryside increases in regard to the average wages, unemployment, and accessibility of services including public transport and health care.

According to national statistics, 24 percent of inhabitants over 15 years of age have only a basic education (8 or 9 years), 35 percent have secondary vocational education, 34 percent have full secondary education and 8 percent have university level education. With the exception of basic education, percentages of the population classified in the remaining educational categories increased during the last 10 years.

As in other European countries, the Czech population is aging. Since 1918, the number of deaths has exceeded the number of births. Also, the size of the population is expected to decline, as shown in table 20.1, and grow older at the same time. Due to prolonged life expectancy, women live 2.1 years longer and men 2.9 years longer than 4 years ago. In 1997, the proportion of the population over 65 years of age was 13.6 percent which signifies a 1.1 percent increase compared to 1987 (12 percent of 65+). Also in 1997, there were 20 people of post-productive age for every 100 people of productive age, which is a rather high level of dependency. Table 20.1 shows that the proportion of seniors over 60 years (post-productive age) will grow more than 4 percent yearly (from present 18 percent of population up to 25 percent in 2010).

Table 20.1 Demographic prognosis

| Age | Proportion of inhabitants (%) | | | |
|-------|-------------------------------|------|------|------|
| | 1995 | 2000 | 2005 | 2010 |
| 0–14 | 19.0 | 18.5 | 18.0 | 16.8 |
| 15–59 | 60.7 | 60.6 | 59.2 | 57.7 |
| 60+ | 20.3 | 20.9 | 22.8 | 25.5 |

Source: Faculty of Natural Sciences of Charles University, Prague.

The Czech Republic belonged to the highly developed countries during its modern history. In its territory, 70 percent of the economic potential of the former Austrian-Hungarian monarchy was produced. Between the first and second World Wars the Czechoslovak Republic was ranked among the 15 most developed countries of the world. The economy was terribly damaged during the communist period; however, it still stayed ahead of the other countries of the Soviet Bloc. The economic transformation was relatively successful till 1997. Since this year, indicators have shown economic crisis connected with the decrease of the GDP (–3.6 percent in 1998 comparing to 1990), increasing unemployment (8.4 percent in June 1999, which is 2.8 percent more than in the same period in 1998), deficit in the state budget, decrease in investments, and 10 percent inflation.

The Health Status of the Population

Until the 1960s, the health status of the Czech population was the best in Europe. The centralist system of health care was successful in the eradication of infectious disease through effective vaccination and better hygiene and sanitation. Since then, growth of the cardiovascular and oncological diseases started to significantly influence the health status of the population. Total standardized mortality rate (SMR) for all causes of death in the CR surpassed the EU by 16 percent in 1970, by 26 percent in 1980, and by nearly 30 percent in 1995. Specific mortality rates due to cardiovascular and oncological diseases were the highest in Europe. While in the countries of EU, the SMR continuously declined as a result of cardiovascular diseases, in the CR it was increasing through the first half of the 1980s when a mild decrease in mortality began. Since 1991, a significant decrease of the SMR due to cardiovascular diseases was observed but did not reach the European level. Previously the number of deaths related to oncological diseases had always remained higher than that in western countries. While the incidence of cancer is getting higher, a mild decrease of the SMR due to malignant neoplasms also began in the 1990s. The distribution of the causes of death is very stable in the CR: cardiovascular diseases represent 56 percent of all deaths, cancer 25 percent, external causes (injuries, poisoning) 7 percent, respiratory diseases 4 percent, diseases of the digestive system 4 percent.

Life expectancy indices showed stagnation during the 1970s and 1980s and in the case of men, it decreased compared to 1960. The 20 years of declining health concerned mainly middle and older age groups. Since 1990, the life expectancy at birth has increased 2.9 years for men and 2.1 years for women. In 1997 it reached 70.5 years for males and 77.5 years for females. It is still 6–7 years less for males and 4–5 years less for females compared to European countries with the highest rates. Analysts say that life expectancy at birth will increase, but will not reach that of the countries of EU until 2020. The only comparable decline to that of western Europe was infant mortality. In 1997 the infant mortality rate reached 5.9 per 1,000 births.

The latest documentation of life expectancy and mortality rates in the CR differs significantly from that of other postcommunist countries. Initially, it was the decline in cardiovascular mortality, particularly amongst older age groups, that caused this phenomenon. A very complex and synergic influence of more factors seems to be the most important. The fact there have been tremendous changes in the health care system, numerous investments in medical technology, improvement in the quality of care, in particular the ability to make earlier diagnoses, more effective medication, and cardiosurgery available to elderly people, has played an important role. Since 1985, the people of this particular population have shown a noticeable change in their lifestyle. This change is indicated by a decrease in fat and milk consumption and an increase in nutrition, intake of more vegetables and fruits. (Drbal 1997; Škodová et al. 1997). Smoking amongst men has also declined over the last 13 years (in 1996, 32 percent of men and 20 percent of women smoked daily).

The impact that environmental conditions had on the relative health status of the population was exaggerated at the end of the 1980s as a means for combating political forces that did not recognize the importance of environmental awareness. The negative impact of air pollution on people's health was evident but its global impact on mortality was minimal. Bobak and Feachem reported that only 2–3 percent of the global mortality in 1987 was caused by air pollution (Bobak and Feachem 1995). The decline of environmental conditions in some parts of the country (Northern and Western Bohemia, Northern Moravia) has been attributed to coal mining, energy production (power plants), heavy and chemical industries, in combination with typical socio-economical and sociopathological phenomena (low education of population, higher unemployment, lower income, ethnic minorities, criminality etc.). While the air and water pollution increased dramatically, the social structure amongst inhabitants of these regions did not change very much (high unemployment being the typical feature) and table 20.2 shows that differences between regions in the health status indices or social risk factors remained.

Table 20.2 Values of the selected demographic characteristics in different typological groups of patients

| | A <i>Districts with the most favorable environment</i> <i>n = 21</i> | | B <i>Districts with the most devastated environment</i> <i>n = 8</i> | | C <i>Difference B – A</i> | |
|---|--|------|--|--------|------------------------------|--------|
| | 1990 | 1997 | 1990 | 1997 | 1990 | 1997 |
| Life expectancy of men | 68.1 | 69.2 | 65.7 | 67.4* | –2.4 | –1.8 |
| Life expectancy of women | 75.4 | 76.3 | 72.7 | 74.5* | –2.7 | –1.8 |
| Standardized mortality per 1,000 inhab. | 11.5 | 9.8 | 13.9 | 11.0 | + 2.1 | + 1.2 |
| Infant mortality | 5.7 | 5.3 | 10.7 | 9.0 | + 4.4 | + 3.7 |
| Abortions per 100 live births | 83.2 | 53.4 | 108.7 | 74.6 | + 25.5 | + 21.4 |
| Divorces per 1,000 inhab. | 2.3 | 2.5 | 4.4 | 4.0 | + 2.1 | + 1.5 |
| Suicides per 100,000 inhab. | 12.2 | 13.6 | 14.0** | 12.9** | + 1.8 | – 0.7 |

* 1995

** 1994 and 1998

Source: IHIS Praha. Typological groups according to Moldan 1990.

A = group of districts with relatively high level of environment, with favorable indicators of social environment and with favorable indicators of mortality, significantly lower than the average of the CR.

B = group of districts with extremely devastated environment, with very bad indicators of social environment and with significantly increased mortality rate.

At the end of the 1980s, the overall reduced health of the population proved to be a major issue, giving rise to a political crisis within the government. In 1990, during the beginning stages of the reformation process, the government declared that improvement of the overall health of the population would be the primary goal of health care reform. However, politicians did not take the proclaimed goal

seriously. This sent health care reform in a different direction throughout the years that followed.

THE HEALTH CARE SYSTEM – RAPID TRANSFORMATION FROM CENTRALIST STATE HEALTH CARE SYSTEM TO THE GENERAL HEALTH INSURANCER AND PLURALISTIC MARKET-BASED MODEL

The Social Climate

As a result of the political changes in 1989, all areas of social life suffered major consequences. The “change” itself as well as the vision of the healing role of the market economy, privatization, diminishing state control, and increased individual responsibility, became dominating ideologies. This increased freedom brought new opportunities to all people involved with the health care system – patients, the state and health care professionals, particularly physicians. Reformation substantially impacted the entire health care system completely changing its financing, organization, and ownership. The rate of change can be explained in terms of the overall reduced health of the population. The accomplishment of this goal would be challenging, not only to policy makers but also to physicians who frequently suffered periods of frustration. However, they honestly believed that increased competition would improve the quality of care and contribute to fair evaluations of their jobs through a fee-for-service system.

Later on, doubts and criticism emerged concerning the speed of reformation. There were also arguments and concerns dealing with the efficiency of correspondence and coherence between health care reform and the processes that were actually taking place in the communities and society as a whole. Health was understood as a commodity and an individual problem, the market was supposed to distinguish between good and bad providers of health care, and also should have reflected the health needs of the population. It was believed that governmental regulation or management in health care was unnecessary (Kalina 1992). Under the influence of liberal ideology, radical changes were implemented without any serious consideration of the needs of society, without a complete evaluation of the previous existing health care system, without comparisons to foreign health care systems and without respecting any warnings from experts abroad. Shockingly, the Institute of Social Medicine in Prague (ÚSLOZ), originally the only institution where any empirical research took place, was abolished in 1993.

In this context, the latest sociological studies have shown interesting results. Health care is one area of the social system in which Czech citizens expect the state to play a strong role. In the Survey on Family and Reproduction, 70 percent of women between 15 and 44 years of age expressed the opinion that the state should bear the full responsibility in the area of health care and care for the elderly (Čákiová 1999: 87). In her latest research, Křížová reports similar results (Křížová 1999 – oral communication). Some 57 percent of respondents believed

that the state would be more effective in regulating health care for the population than insurance companies. An international comparative study (Večerník and Matějů 1998) showed that in the CR only 17 percent of inhabitants were convinced that hospitals should be private property. Ninety-seven percent agreed that the government should assure health care for people, and 83 percent believed that the government should increase expenditures for health care (Večerník and Matějů 1998). Also, the Charter of Basic Human Rights, which has become a part of the Czech Constitution, says that the state guarantees every citizen the right to free health care provision on the basis of general health insurance as well as for the preservation of healthy living conditions. Contrary to the charter, major forces of the Czech health care system – particularly physicians – implemented complete change in the financing and organization of health care provisions. From their point of view, they believed that the change would fulfil the following important goals:

- improve their socioeconomic position
- extend their diagnostic and therapeutic possibilities (new drugs, technology) and thus improve the quality of care for patients
- supply more sources
- improve effectiveness and management of the health services

Later developments not only disappointed physicians but also the public.

Principle Changes in the Health Care System Organization (1989–1999)

The former health care system had a fixed organizational structure based on the Regional and District Institute of National Health, which integrated all health facilities in the given territory. The Ministry of Health (MoH) supervised the quality of care through the main specialists (central, regional, and district) in all medical branches. The MoH was also responsible for legislation, medical research, situations concerning hygiene, and drug policy. All health facilities had their catchment areas, so that patients could not select their own physicians. This system formed a dense network of basic health services, easily accessible for people, with well-developed preventive health care for younger generations, dental care, and health promotion strategies. The primary problems of the old health care system were the lack of financial sources, old and insufficient medical technology, lack of drugs, lack of motivation for professionals, black market, bribes, and animosity between health care professionals and patients. At the beginning of reformation, ethical challenges were very taxing.

The first step of the transformation (1990–2) led to the abolition of this centrally organized structure, which seemed highly ineffective. The state monopoly was unacceptable because physicians suffered from a shortage of financial resources and from a lack of clinical freedom. Individual health facilities obtained legal and economic independence. Later they were either privatized (particularly smaller health centers, i.e. primary care and special ambulatory care) or in the case of a few hospitals transferred to communities or churches. Most hospitals remained in the hands of the state controlled by the District

Authority (the Health Department) or, in the case of large or teaching hospitals, under the control of the Ministry of Health.

Though removal of state control was the dominant philosophy of most health facilities in that period (1992–3), frequently the process was unsuccessful for economic and legal reasons. For hospitals, it was very difficult to profit. Some of them fell into tremendous debt. Legislation regarding the not-for-profit sector was missing. In fact, reform of the health sector was simplified and reduced to the mere privatization taking place in industry and business. It was more an ideological affair than a reasonable, well-prepared and coordinated process, because it cost too much energy and too much money. Thousands of privatization projects were elaborated and passed through privatization commissions established in each district. The projects were assessed from many aspects (privatization design, economic effect, solvency of the proposer, etc.) but first of all the privatization of property should not have threatened the accessibility of the health care for the population. At present, process of decentralization and privatization is virtually finished. More than one-half of all physicians work in private sectors.

In 1998, there were about 25,000 individual health facilities in the CR (out of the original 142 state health organizations existing before 1990). Most of them were private practices of GPs, GPs for children, gynecologists, and dentists, who had traditionally formed the network of primary care. Practically all ambulatory specialists were private, too. Some physicians formed an association or a company and privatized a polyclinic or another health facility together.

The state owned about 685 health facilities. Of those 685 facilities, 27 were large regional and university hospitals directly managed by the MoH and 82 were hospitals managed by the District Authorities. Cities or communities owned 261 health facilities. Of those 261, 43 were hospitals. Some 64 hospitals belonged to the church or to other private entities.

Health Care Financing Reform

Before reform, health care in the Czech Republic was financed exclusively through the state budget. Health care made up about 4 percent of the GDP. There was a substantial shortage of sources for expensive drugs, modern medical technology, modernization of buildings, and adequate wages. The lack of economic incentive discouraged health care professionals in their work. The population's limited access to many health care services gave way to a black market and under-the-table payments. These factors made up the principal causes of the common crisis of the Czech health care system in the 1980s. Even before 1989, some proposals were submitted to increase the functional and organizational autonomy of the Regional and District Institutes of National Health.

Czech reformists adopted the model of general health insurance as the main source for health care financing because of its tradition in this country before World War II. The corresponding legislation was prepared very quickly and passed by the Parliament in 1991–2 under significant political pressure.

Health insurance companies were built as public institutions established by law to collect and administer the resources of public health insurance. The largest one, the General Health Insurance Company (GHIC) came into existence in 1992. Shortly after the GHIC, the government also allowed other health insurance companies (HICs) for some professional groups like police, military service, miners, and bank employees. The lack of legal possibilities for cost containment under the fee-for-service system and the lack of rules for dealing with public sources led to a misuse of general insurance sources to accommodate the private interests of health care providers or pharmaceutical companies. This led to the progressive deterioration of financial stability in the insurance system.

The New Public Health Insurance Act, adopted in 1997, brought the most substantial changes in health care financing since 1992. It clearly defined the fund's ability to impose limitations in contracts with health care providers and permitted alternate payment schemes aside from the fee-for-service system. The new legislation also intensified the public's control over actions taken by HICs, so that they had to present annual reports for approval in the Parliament. Along with bankruptcy, this was another way to reduce the number of HICs. In fact, the number of HICs decreased from 27 in 1995 to the present figure of 10.

General health insurance is not the only financial source for health care in the CR. The State has also been involved. Large investments, research, postgraduate education, activities for regional and district hygienic centers, preventive activities, and health promotion programs are financed from the state budget. Districts and cities can also contribute to the development of health care from their budgets. For some procedures (unrelated to health status, such as those for cosmetic reasons, license to drive, etc.) citizens pay directly in cash.

The total proportion of the GDP that health care expenditures occupy reached 7.20 percent in 1997, which was approximately 11,500 CZK per capita (\$330 US).

Health insurance is mandatory for all citizens of the country. Premium contributions are by law defined as a percentage of personal income. Employees pay 4.5 percent of their wages, while employers pay 9 percent. Combined, this figure equals 13.5 percent. Self-employed persons and those with income from capital pay premiums from 35 percent of their profit. However, there is a ceiling to contribution, which is set at about six times the average salary in the Czech Republic. The problem is that thousands of self-employed persons do not pay their contributions due to weak monitoring by the government. Also, many employers owe contributions. For example, in 1998 employers' debts to the GHIC reached more than 10 percent of the total budget, while its administrative expenditures were a mere 4.6 percent.

For those who do not have their own income, the premium is paid by the state. This category, which represents 50 percent of the population, is composed of children and students, pensioners, women on maternal leave, unemployed people, recipients of social support, and other social groups. The premium for these people is very low as derived from their minimal wages. To adjust the selection of insurees and prevent economical problems due to a disadvantageous age

structure, 60 percent of the income of each insurance company is redistributed according to the number of the state insurees with special regard to the age. All insurance companies are open to insure anybody who asks. Thus, citizens are free to select their insurance company, though 76 percent of citizens are insured by the GHIC, because its solvency is guaranteed by the state.

Practically all necessary care for the population is covered by the mandatory health insurance, such as diagnostic and therapeutic care in ambulances and hospitals including room services, care for chronically ill, prevention, drugs, transport of patients, special health care and spa care. The contract between the insurance company and the health facility defines the conditions of the reimbursement. HICs can apply regulative measures, which influence economic behavior of the health care providers.

Originally (between 1993 and 1997) the health care provided by physicians and hospitals was paid for through a fee-for-service system. In this system, the number of provided services increased dramatically, which consequently increased the costs of health care. The lack of sources for reimbursement of this increased amount of services led to the introduction of a capitation system for GPs (with some services paid through fee-for-service), lump-sum payments to the special ambulatory services, and budgeting for hospitals in 1997. This step was successful because it ended "procedures hunting" and helped the system to survive. At the same time, the motivation structure for providers was changed so that the amount of care was minimized. According to statistics from HICs, the real decrease in medical procedures reached 20 percent (Jaroš 1998: 34).

Health Care Professionals

For physicians, radical organizational changes in the health care system and its financing meant also radical changes in their social position. As employees of centrally managed health organizations they had little possibility of reaching a significant professional or social position. Their wages did not differ very much from the societal average and were often lower than those of manual laborers (Vecerník 1998: 121). Thus, physicians were not motivated to improve or intensify their work. They did not have enough medical technology, foreign drugs, and experience from abroad to provide medical care that met their personal standards. Physicians' frustration was high, which was reflected in the declining medical ethic and tension in relations between professionals and patients.

Physicians wanted to use new chances as quickly as possible, so they participated very intensively in the creation of the new health policy. However, they also created many of its problems. A content analysis of the health care press (Janečková and Hnilica 1996) showed that articles regarding professional identity of physicians were a high priority. Their representative body – the Medical Chamber – was frequently discussed in the health care press. It was already an institution in 1991, embodying the ability of the professional group to exist autonomously in order to guarantee the high quality of health care and to maintain the norms of medical ethics. Later this group became a sort of trade union organization representing the economic interests of physicians.

The topic of physician wages always culminated in the health press with hopes in vain. First, shortly after the beginning of the transformation between 1991 and 1992, strong physicians lobbied in the Parliament to influence the direction and speed of the reforms. Later in 1995, the expected economic effect of the first transformation steps did not occur so physicians decided to strike. The wages of employed physicians are still not comparable with wages of similar professions in the CR but they are twice as high as the country's average wages.

The supply of physicians is frequently discussed in connection with their wages and risk of unemployment. In the CR there were 36,676 physicians in 1997, which was 36 per 10,000 inhabitants and represented 16.4 percent of health care professionals (6.3 other health personnel per one physician). The number of physicians in the CR increased in the 1960s and 1970s as compensation for the lack of imported medical technology and drugs. However, the 20 percent growth in the number of physicians during the last 10 years corresponds with the improvement of the health status of inhabitants since 1990.

Physicians in the CR continuously find themselves in a difficult plight, not only because of inadequate wages, but more generally because of the very unstable milieu in which they work. It is caused by ever-changing conditions for physicians' work reimbursement, by unsolved ownership conditions (in many cases), and finally by uncertainty about physicians' contracts with the HICs. One last frustrating situation is the difficulty in providing care of the highest quality because of a lack of resources.

Patients – Subject or Object of Health Care?

From the patients' point of view the transformation should lead to better quality health care and healthier conditions for life. Democratization and humanization of health care were the key to citizens' higher satisfaction with health provision, but citizens also need to increase their general interest and involvement in health care. In fact, the public's opinion about individual reform interventions has not been systematically studied. The politicians who were shaping the new health care system did not prioritize the empowerment of citizens in the area of health care.

The principal steps of the reform – decentralization, privatization, and health insurance – concerned health care professionals rather than patients. Patients were not supposed to recognize any change in the accessibility of services or financing. Nonetheless, there were many changes for patients during the transformation. The most important changes are the following:

Free choice. Patients received the right to health care and healthy living conditions through the Charter of Basic Human Rights. They are obliged to participate in the general insurance system. By law, the state has carried responsibility for the accessibility of health care for all citizens since 1966. The law is still valid but some amendments have been made, with one in particular regarding the right of citizens to choose their physician, health facility, and health insurance company. Only a small portion of patients took advantage of this amendment: only 5 or 10 percent changed physicians, usually patients in large

towns with higher education. It is practically impossible for the average patient to decide what physician or health facility is actually the best. Free choice also enabled some patients to circulate between multiple physicians with one health problem. Thus, the psychological effect of free choice is combined with an increase of costs in health care. For the best application of free choice, it would be necessary for health insurance companies and hospitals to publish regular information about measures such as their quality assessment, accreditation, and patient satisfaction. This system has not yet been implemented in the CR.

Better relationships between professionals and patients. Patient emancipation in a democratic society is also connected with the changed role from passive consumer of the physician's instructions into a partner who can discuss his or her health problems with a physician or a nurse. This new concept of the patient's position is expressed in the Charter of Patients' Rights. Even if it is not a legal document, it was approved by the Central Ethical Commission of the MoH and is generally applied in Czech hospitals. Surveys of patient satisfaction have become a regular part of the quality improvement of health care, and they are applied at about 30 percent of Czech hospitals (Janečková 1997; Hnilicová 1998). The research also showed typically high levels of patient satisfaction in Czech hospitals (89% of patients were either satisfied or highly satisfied). Overall satisfaction with hospital care was significantly related to a high level of satisfaction with the professionalism and commitment of physicians and nurses.

Better quality of care. Between 1992 and 1995, hospitals and ambulances were continuously equipped with new medical technology and a wide supply of high-quality drugs became available. Many physicians got the opportunity to study abroad and to learn new methods of treatment. The fee-for-service system motivated physicians to offer more procedures to their patients than ever before. The higher accessibility of new medical procedures and modern drugs is the crucial factor in the health status improvement of the Czech population after 1990. Since 1997, quality care has become a priority, and a system of criteria for assessing quality has been developed (Hnilicová 1994).

Cost sharing. With expanding economic problems in the health care system a new question connected with patients has arisen. Until now, health insurance has covered more than 90 percent of all possible care. Statisticians have documented that private expenditure for health care is nearly 9 percent of total health care budget which is on average about 1,000 CZK (about \$30) per capita a year and is much less than in the countries of the EU (where it is estimated to be 22 percent). The sum includes all direct payments or co-payments of patients for drugs and medical aids, above-standard dental services, cosmetic operations, abortions, and services provided for non-health reasons.

There is no legal possibility for copayment in the case of care that is fully covered by the health insurance. But there is a rather strong tendency on the part of the provider to increase co-payments of patients – either legally or illegally. Patients are often asked for “donations,” especially for services where coverage from insurance companies is not sufficient according to the opinion of physicians and managers (e.g. in case of long-term care for elderly).

There is no proof that the amount of traditional bribes to physicians increased. But a renewed occurrence of waiting lists for operations and examinations due to the new prospective system of financing since 1997 (capitation and budgeting) has reopened the discussion about ways to involve patients more in the financing of health care.

Inequalities. Transformation of the whole society has brought diversification to the social structure of the society and, in connection with the transformation of health care reform, consequences for equity and equality of health care can be observed. Czech sociologists have paid considerable attention to this phenomenon since the beginning of the 1990s (Janečková 1992, 1996, 1998; Křížová 1998). Differences were studied in relation to education, age, region, sex, and ethnicity. Because of the rapidly changing health care system, with growing complexity that necessitates more information for patients who want to face the challenges of individual choice and individual responsibility, it is relevant to consider the question of decreasing accessibility for certain social groups.

An analysis of health indicators in various regions of the Czech Republic shows stable differences. For example, life expectancy at birth for men in Prague is three years longer than in Northern Bohemia, which is an industrial region with high levels of social pathology, lower education, and a high proportion of ethnic minorities. For women, the difference in life expectancy between the best and worst regions is two years. There are also interregional differences in the distribution of health services. The highest concentration of hospitals is in the capital of Prague as well as in other big cities, and also in Northern Bohemia. However, primary care is developed less in this last region.

Among social groups, seniors are worth mentioning. Elderly people were treated insufficiently until 1990, compared to their western counterparts (life expectancy at 45 was even worse than the average for East Europe). Since then, elders' life expectancy has rapidly increased and reached the European average in 1994. Their mortality rate significantly decreased. However, the assurance of institutional capacity and home care for seniors with disabilities is still a problem that has not yet been addressed. Access to this type of care, the gap between health and social care, and speculations about its financing have all been lasting problems of the Czech health reform.

With regard to women's health Křížová (1995) showed that differences between women and men are caused not only by biological factors, but also by sociocultural determinants. Women's social position at work and in the family of modern society plays an important role. Aging is mostly a woman's problem and their added years are associated with a greater rate of illness. During the period between 1989 and 1996, Czech women's life expectancy increased by only 1.87 years, while men's increased by 2.26 years. The health interventions ensuing from the transformation of the health care system seem to be less effective in the case of women. Women need health services more often, suffer from a lack of information about medical procedures, need more psychological support, and consume more medicaments. The health care system should reflect more of the specific needs of women in its financing.

Roma gypsy ethnic minority is another social group threatened by unequal chances to improve their health status. At present, data indicate this minority's

worse health status (shorter life expectancy, higher infant mortality, more infectious diseases, social deprivation, alcoholism, drug addiction, diabetes, respiratory diseases, and injuries) and some peculiarities in health care consumption (insufficient use of preventive and specialized care, lack of cooperation with physicians in therapy, misuse of primary care, and delay in visiting a health center in case of serious problems). Their health status is probably worse due to the very specific lifestyle of this ethnic minority that includes many health risks connected to low education, high unemployment, and poverty. In spite of the many problems that the Roma minority has at present, it has not been politically acceptable to study specific health indicators in connection with ethnicity because this is seen as contradictory to the equal rights of all citizens. Křížová calls this praxis “alibistic” because in fact “it covers up the existing social and health inequality, not admitting it” (Křížová 1998). Finally, in 1999, the MoH provided a grant for the research of the health status of Roma under the pressure of international criticism of the Czech policy towards ethnic minorities (Nesvatbová 1998).

Patients' Associations. Shortly after the change of the political system in November 1989, citizens got the chance by law to create civic associations in the non-governmental sector. People with various diseases and handicaps began to create self-help groups. There are about 150 such associations in the field of health care at present. They can receive some financial support from the MoH and Ministry of Labor and Social Affairs as well as from international foundations. In spite of the high level of financial and legal uncertainty that they face, these associations offer a number of services which address the specific needs of their members, such as home care agencies, hospices, centers of early intervention, helplines, rehabilitation centers, and sheltered homes.

THE ROLE OF MEDICAL SOCIOLOGY IN ASSESSING HEALTH CARE REFORM IN THE CZECH REPUBLIC

Although there has not been a direct demand by politicians, some attempts have been made to analyze the ten-year transformation of the health care system in the CR. There is only a very limited institutional basis for doing complex analyses and large research projects of systematic collections of empirical data. The 1993 abolition of the Institute of Social Medicine and Health Care Organization, the only state research institution in this field, thus represented the attitude of the liberal government toward intellectual and evaluative work as a source of valid information for decision-making.

Besides the Institute of Medical Information and Statistics (ÚZIS) – a governmental organization responsible for national health information systems and yearly statistics – there are several nongovernmental initiatives, largely on the part of Czech universities. These facilities' research activities are usually based on grants from the Ministry of Health, for whom social research has not been a priority until now. The number of active sociologists with an interest in health care has also been minimal.

Sociological analyses of the transformation process occurred only recently. Křížová (1998) identifies the absence of the vision in her studies as the

principal problem of Czech health care and its “oscillation between the state health care system and mixed general health insurance system.” This resulted in a hybrid system, which maintained some negative features of the previous socialistic system (i.e. totally free services at the moment of consumption and ineffective use of sources) and didn't introduce certain useful elements of the national health insurance system like control mechanisms. It would have been better for the country to have adopted a clear perspective, either transition of the centrally managed system into a form of National Health Service (with complementary private sector and a strong private primary care) or its global transformation to the decentralized and pluralistic model of general health insurance. This second alternative won, but the preparation of necessary legislative and economic preconditions was underestimated.

Křížová (1999) also negatively evaluates the government's failure in the case of needed interventions into health care, its lack of a basic concept and vision, and the lack of reflection on the transformation process. Because the public interest was not well-defined both spheres – private and public – became intermixed and confused. The social and ethical dimension of private property was suppressed, so the possibility of a private not-for-profit sector in health care was underestimated and practically lost its chance in the transformation process. Finally Křížová points out the problem of poor communication by all partners in the process, which was previously stigmatized by history – the authoritarian decision-making, refusal of any criticism, and incapability of negotiation. The voice of providers in this case was stronger than that of consumers. After ten years, the process of transformation is once more at a crossroads and the same choices must be considered anew. At both times, the market must be taken into account as a complementary mechanism and the public must undertake a discussion about the consequences of any choice. Improvement of the existing system seems to be simpler than a complete change.

Patient satisfaction research represents another important topic in Czech medical sociology and provides information about the satisfaction of patients with their hospital care (Hnilicová 1998). The contribution of this activity to quality of care improvement is generally well known. Until recently, the bad economic situation did not allow hospitals to employ sociologists. It is necessary to add that some smaller sociological studies exist in the frame of various medical branches and can be characterized as sociology in medicine. This is especially the case in gerontology, with special regard to the caregivers' burden, childcare, primary medicine and health promotion, various chronic diseases, and drug abuse. Types of communication, ethical aspects, life events and hardiness, the family, and social risks were all studied in this context. Team collaboration was typical in such studies that connected sociologists, psychologists, and physicians (Matejcek 1988; Bútorá 1990; Kabele 1991). As this direction of medical sociology was less politically engaged, it could exist even during the communist period and helped many sociologists to survive. After the revolution in 1989, nearly all sociologists active in medicine left the field. This is why the new, analytical, period of medical sociology had to wait till the second half of the nineties.

CONCLUSION

All sociological analyses of the transformation process until now have shown that rash solutions and inconsistent reactions to the emerging problems hindered the process. Subjective opinions of the political leaders or of the lobbying groups dominated over expert analyses and outcome-oriented evaluations of the course of transformation. The absence of rational conceptual work was repeatedly stressed as the most unfortunate feature of the Czech health care reform. Many criticized the lack of analytical reflection on the process. Two elements of the “reform culture” in the Czech Republic are underestimation of the systematic development of social research and total ignorance about measuring outcomes of the reform steps. Building institutional bases and professional capacities for evaluative studies either at universities or elsewhere represents a very important task in connection with the future reform steps.

At the present time there is another strong element of the reform – a more developed civic society with active involvement of citizens. Various associations of providers and consumers came into existence and contribute to the discussion on various aspects of the reform. They debate both with each other and with the government, and they have more opportunities to express their dissatisfaction. They even form coalitions and try to present their common proposals. This mutual balancing of different partners and forces will certainly play an important role in the process of transformation in the future.

Abbreviations

IHIS – Institute Health Information and Statistics of the Czech Republic
 ŠVZ – School of Public Health
 IPVZ – Institute of Postgraduate Medical Education
 MoH – Ministry of Health
 HIC – Health Insurance Company
 GHIC – General Health Insurance Company
 ÚSLOZ – Institute of Social Medicine
 SMR – Standardized Mortality Rate

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